**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

KYLE JONES MD
1025 DESHONG DRIVE
PARIS TEXAS 75460

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 54

**MFDR Tracking Number**
M4-12-0176-01

**MFDR Date Received**
SEPTEMBER 19, 2011

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "This service was billed in a timely manner and all requirements met for proper billing. The note clearly shows this was a case management service that was provided on this date."

**Amount in Dispute:** $113.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The documentation does not reflect a conference with a team unless team is to be re-defined as one person, the requestor. Nor does the documentation reflect a telephone call to another member of the 'team' No coordination took place. The requestor reviewed his medical records then made a decision to refer the claimant back to Dr. Syed. There is no indication he discussed that with anyone present or by telephone. No payment is due for code 99361 as no case management activity took place."

**Response Submitted by:** Texas Mutual Insurance Co.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| February 1, 2011 | Case Management Services – CPT Code 99361 | $113.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008 sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - CAC-W1-Workers compensation state fee schedule adjustment.
   - 892-Denied in accordance with DWC rules and/or medical fee guideline.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- 744-Does not meet the definition of case management per DWC rule 134.202 and/04 134.204.
- 891-No additional payment after reconsideration.

**Issues**

Does the documentation support billed service per 28 Texas Administrative Code §134.204(e)? Is the requestor entitled to reimbursement?

**Findings**

- 28 Texas Administrative Code §134.204(e) states "Case Management Responsibilities by the Treating Doctor is as follows: (1)Team conferences and telephone calls shall include coordination with an interdisciplinary team.
  (A) Team members shall not be employees of the treating doctor.
  (B) Team conferences and telephone calls must be outside of an interdisciplinary program.

  Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call."

The submitted report does not indicate a team conference with an interdisciplinary team nor does the requestor document a phone call.

- 28 Texas Administrative Code §134.204(e) states "Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:
  (A) CPT Code 99361.
    (i) Reimbursement to the treating doctor shall be $113. Modifier 'W1' shall be added."

A review of the submitted medical bill finds the requestor billed CPT code 99361-W1. The documentation does not identify any HCP that contributed to the case management activity.

The Division finds that the requestor did not support billing for case management services per 28 Texas Administrative Code §134.204(e). As a result, reimbursement is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 10/18/2013<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.